Alberta Patient Safety Survey Highlights

Background

Canada believes it has one of the safest health systems in the world. At the same time, recent research in Canada and around the world is highlighting patient safety and medical errors. In 2003, a Canadian Institute for Health Information survey found that 24% of Canadians reported they or a family member had experienced a preventable adverse event related to their care. Of those who had experienced an adverse event, about half (52%) said the most recent event had resulted in serious health consequences.[1]

A 2002 US study found 42% of those surveyed said that they, or a member of their family, had experienced a preventable medical error in their care at some point in their life. Fifty-six per cent (56%) of the 42% said that the latest medical error had resulted in serious health consequences.[2]

A 2004 study of patient medical records by Baker Norton et al,[3] which looked at the incidence of adverse events among adult acute care hospital patients in Canada in 2000, found an estimated 7.5% had experienced one or more adverse events. Nearly 37% of these patients were judged to have experienced highly preventable adverse events.

1 Canadian Institute for Health Information (survey conducted by The Berger Population Health Monitor). (Toronto: CIHI, 2004).

2 R.J. Blendon, C.M. DesRoches, M. Brodie, J.M. Benson, A.B. Rosen, E. Schneider, D.E. Altman, D. Zapert, M.J. Hermann, A.E. Steffenson, "Views of Practicing Physicians and the Public on Medical Errors," New England Journal of Medicine 347, 24 (2002): pp. 1933-1939.

3 Baker G.R., Norton P.G., et al. "The Canadian Adverse Events Study: The Incidence of Adverse Events in Hospitalized Patients in Canada," CMAJ 2004 May; 170(11): 1678-86.

*Note: the following are not actual participant experiences, as we did not request consent to publicly share Albertans' private stories. These stories represent the nature of the experiences we did hear and are included to add meaning and life to the *Alberta Patient Safety Survey Highlights*.

*Her medical chart said that she was allergic to penicillin, but the nurse still insisted on giving it to her. Thankfully, I was able to convince her nurse before it was too late. She could have died.**

Why a patient safety survey?

In 2003, the HQCA released *Satisfaction with Health Care Services: A Survey of Albertans 2003*. It was the Council's first province-wide survey that looked at how Albertans assessed quality, safety and satisfaction with services provided by the publicly funded health care system. The survey found that next to accessibility, patient safety was the most important factor Albertans associate with overall quality in the health system.

The survey also found that 30% of those Albertans surveyed were concerned about patient safety. Fourteen per cent (14%) reported they or an immediate family member had experienced a medical mistake within the past year that resulted in serious harm such as death, disability or additional prolonged treatment.

These numbers were corroborated in 2004, with 33% of those surveyed saying they were concerned about patient safety and 13% reporting they or a family member had experienced a medical mistake in the past year.

Based on these findings, the HQCA decided to learn more about Albertans' perceptions of and actual experiences with medical errors, including specific details about the circumstances surrounding experienced errors.

HQCA
Health Quality Council of Alberta

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"To err is human, but errors can be prevented. Safety is a critical first step in improving quality of care."

Institute of Medicine: To Err is Human: Building a Safer Health System, 2000

How was the survey done?

The HQCA contracted an independent organization, the Population Research Laboratory at the University of Alberta, to conduct a telephone survey of a random sample of 1,500 Albertans 18 years or older. Survey questions were based on a survey done in the United States by the Kaiser Family Foundation/Harvard School of Public Health, and were modified to reflect Alberta's health care system. The telephone interviews took place in April and May 2004, and also solicited specific details if the respondent or a family member had experienced a medical error.

Four hundred survey respondents lived in the Calgary Health Region and 400 were from the Capital Health Region. One hundred survey respondents were selected from each of the seven other health regions throughout Alberta. The sex and age composition of the sample of respondents was similar to the 2001 Alberta census. This provides approximate accuracy levels of ±5% 19 times out of 20 for the Calgary and Capital health regions, ±10% for each of the smaller regions, ±4% for the combined group of seven smaller health regions, and ±3% for the entire province.

Every year for the past few years, I had been complaining to my doctor of a pain in my lower abdomen. It was continually dismissed as digestive problems, until last year I visited a new doctor and was diagnosed with colon cancer. I believe that it would have been treatable if they caught it earlier.*

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What did the survey find?

Overall, the survey found that the majority of Albertans surveyed perceive the health care system to be safe. At the same time, the survey results suggest that Albertans have some concerns when it comes to patient safety. The following are highlights of what Albertans had to say.

- 95% felt physicians should be required to tell the patient or the patient's family if a preventable medical error resulting in serious harm is made in the patient's care.
- 26% of surveyed Albertans responded "very often" or "often" when asked how often health professionals made preventable medical errors that result in serious harm to the patient.
- 66% felt overwork, stress or fatigue of health professionals was a very important cause of preventable medical errors that results in serious harm to the patient.
- 74% of those surveyed felt requiring hospitals to report all serious medical errors to a provincial agency would be very effective in reducing medical errors.
- 37% indicated they or a family member had experienced a preventable medical error while receiving service within Alberta's health care system anytime throughout their lives. Of this 37%, 63% didn't receive an apology from the doctor or other health care professionals.
- Albertans surveyed who had experienced a medical error feel they are not listened to or heard and their concerns, issues and opinions are not valued, which they feel may contribute to medical errors.
- Those Albertans surveyed who had experienced a medical error feel that poor attitudes of health care professionals and a lack of caring about patients or their jobs play a large role in the events surrounding medical errors.

How do Albertans perceive preventable medical errors[4]?

When those Albertans surveyed were asked how often health professionals made preventable medical errors that resulted in serious harm to the patient, 26% said very often or often.

The majority of those surveyed (57%) felt mistakes made by individual health care professionals were the more important cause of medical error, rather than mistakes made by health care institutions where the health care professionals worked.

Forty-nine per cent (49%) felt patients were at least partially responsible very often or somewhat often for preventable medical errors made in their care. Nearly half (49%) felt a medical error would be more likely to occur at a hospital that does not do as many of a specialized medical procedure. Almost 50% said their knowledge about medical errors was based on what they had seen, heard or read in the media.

What are their perceptions of possible causes of preventable medical error?

When survey participants were asked to respond to a list of possible causes of preventable medical error, the majority felt the following were "very important" causes:

- Overwork, stress, or fatigue of health professionals;
- Doctors not having enough time with their patients;
- Not enough nurses in hospitals; and,
- Health care providers not working together or communicating as a team.

Those Albertans surveyed also gave the following as very or somewhat important causes of preventable medical errors:

- Medical care being very complicated;
- Poor handwriting;
- Poor supervision of health professionals;
- Poor training of health professionals;
- Uncaring health professionals; and,
- Lack of computerized medical records.

Perceived effectiveness of possible solutions for preventing medical errors

When participants were asked to respond to a list of proposed solutions to prevent medical errors, nearly 75% of respondents felt requiring hospitals to develop systems to avoid medical errors and to report all serious medical errors to a provincial agency would be very effective strategies. Sixty-one per cent (61%) felt reducing the work hours of doctors in training to avoid fatigue and 60% felt giving doctors more time to spend with patients would be very effective in reducing medical errors.

The majority also felt the following would be very or somewhat effective in reducing preventable medical errors:

- Limiting certain high-risk medical procedures to hospitals that do a lot of them;
- Using more computerized medical records;
- Including a pharmacist on hospital rounds when doctors review patients' progress;

[4] Medical errors refer to mistakes made during medical care that result in serious harm, such as death, disability or additional prolonged treatment.

"Medical mistakes are most often caused by systems that break down and don't support the highly qualified and dedicated hospital caregivers the way they should."

The Leapfrog Group for Patient Safety

"The health care system must develop an atmosphere of trust, in which openness and frankness in identifying and reporting problems or potential problems is encouraged and rewarded."

- Suspending the license of health professionals who make medical errors;
- Having a government agency fine health professionals who make medical errors; and,
- Having hospitalized patients taken care of by hospital doctors rather than their regular doctors.

In contrast, nearly 60% felt more malpractice lawsuits would not be very effective or not at all effective in reducing preventable medical errors.

In addition to being asked their opinions about a list of proposed solutions, survey participants were also asked to share what they considered to be possible solutions to prevent medical errors. Although many ideas were shared, the most common were:

- Increasing and improving the use of resources;
- Improving communication and striving for a team approach to health care;
- Making system level changes such as addressing fatigue, stress and/or workload of health care practitioners;
- Increasing communication between health care practitioners and patients; and,
- Removing delays and increasing the time health care practitioners spend with their patients.

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What about confidentiality and disclosure?

The majority of Albertans surveyed felt mandatory or voluntary reporting of preventable medical errors to a provincial agency was a possible solution to prevent medical errors, and almost 50% felt the reports should be released to the public.

Almost all respondents (95%) felt physicians should be required to tell patients or the patients' families if a preventable medical error resulting in serious harm is made in the patients' care. However, only 52% said it was very likely or somewhat likely that the doctor would tell them.

*Last summer I fell off my bike and got a big gash in my leg that needed stitches. I thought it was weird that the doctor never cleaned the wound before stitching it up, but I didn't say anything at the time. A few weeks later it got infected and I had to have the stitches removed and replaced and had to take antibiotics for a while. It was quite painful.**

Albertans' personal experience with preventable medical error

Thirty-seven per cent (37%) of those surveyed indicated they or a family member had been involved in a situation where a preventable medical error was made while receiving care in Alberta's health care system anytime throughout their lives. Of this 37%, over half said the error resulted in serious health consequences that included:

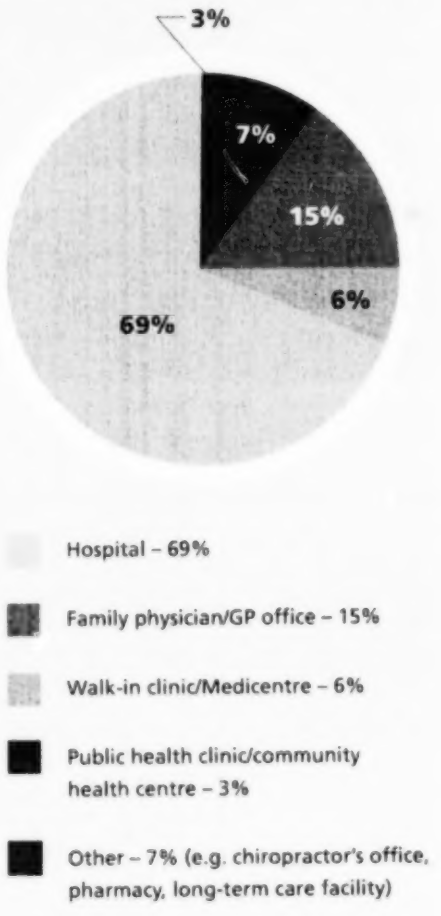
- Significant loss of time at work, school or other important life activities (79%);
- Severe pain (78%);
- Temporary disability (64%);
- Long-term disability (54%);
- Death of a family member (36%); and,
- Other serious health consequences (41%), including emotional trauma, depression, stress and further treatment or hospitalization.

Those Albertans that had personal experiences with preventable medical error shared a wide range of stories. These experiences varied in severity and highlighted the complexity of the health care system, as well as the fact that it is used, accessed and perceived in a variety of ways. In total, those surveyed shared 531 stories.

The stories that surveyed Albertans shared were grouped into categories of similar experiences with preventable medical errors. The most common categories include errors relating to:

- The performance of a health care provider – including when they believed he or she did not follow a procedure properly and when they believed a health care provider made a human error.
- The process of obtaining medication or a prescription – including receiving the wrong dose of a medication or not receiving medication when it was needed.
- Receiving a diagnosis – many participants described a misdiagnosis or a delayed diagnosis as a preventable medical error.
- Communication – when communication between anyone, including patients, their families and health care providers, was uncoordinated or insufficient.

Where did the medical errors happen?



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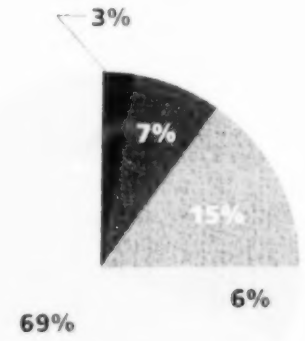

Hospital – 69%

Family physician/GP office – 15%

Walk-in clinic/Medicentre – 6%

Public health clinic/community health centre – 3%

Other – 7% (e.g. chiropractor's office, pharmacy, long-term care facility)

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"Safety is a fundamental aspect of quality health care. To improve safety, the healthcare system must develop, maintain and nurture a culture of safety."

– National Steering Committee on Patient Safety, *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*

Most of the participants shared their thoughts on how the experienced error could have been prevented. Commonly stated beliefs include:

- Clinical performance – e.g., if further diagnostic tests had been completed.
- Communication – e.g., if there had been better communication between health care providers.
- Time – e.g., if more time had been spent with the patient or if care had been received in a timely manner.
- Practitioner attitude – e.g., if a health care provider had paid more attention to or listened to the patient.

Of those who had experienced a medical error, nearly all of the respondents (95%) said they or their family members didn't sue the health care professional for malpractice.

*My son went back to school three days after having his appendix removed. I got a phone call from the school nurse the first day back asking me to go pick him up because he had strained himself during gym class. No one at the hospital told us he wasn't allowed to participate in sports for a month or so after the operation.**

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Reaction of health care providers to medical error

Sixty-six per cent (66%) of Albertans surveyed said they were not told the medical error had occurred. While expert research has shown that the majority of people who experienced medical errors want an apology, the survey found 63% of those who had experienced a medical error did not receive an apology from the doctor or other health professionals.

What did we learn from Albertans' stories of medical errors?

From the many personal experiences that those surveyed shared, five key themes emerged. It is important to note these themes are not just people's general feelings about the health care system; rather, the themes are tied to the circumstances surrounding medical errors that these Albertans personally experienced and what they felt could potentially cause medical errors.

Nevertheless, they have provided some general orientation to medical errors and prevention strategies that could be explored to increase patient confidence and to potentially prevent medical errors.

- A team-oriented approach to health care, where communication, coordination and cooperation between health care professionals could be improved.
- Participants felt they were not listened to or heard and that their concerns, issues and opinions were not valued.
- Albertans felt many health care professionals have poor attitudes and don't care enough about their patients or their jobs.

- The health care system is stressed and health care professionals are overworked.
- Time is a big concern. Albertans surveyed felt they are waiting too long to access health care services. Once they do get to see their doctor, there is not enough time for their doctor to get to know them, to truly understand their concerns, and to contemplate the best treatment.

What's next?

When it comes to patient safety, we can and should do more as individuals, as health care providers, as institutions and as a society. Health care providers are accountable for their actions, but they are working in systems that are not always optimized. It is important to understand and learn how systems can be improved to assure quality and safety. It is important to create an environment that is capable of preventing errors from occurring in the first place, that encourages open reporting of medical errors when they do occur, and that incorporates lessons learned from any errors that do occur.

The Health Quality Council of Alberta is currently involved in a number of initiatives focused on improving safety in the health care system. Through the Health Quality Network, a collaborative that represents health regions, health professions, associations, boards and government, we are developing a provincial framework called *Disclosure of Harm to Patients and Families*, which provides guidelines for sharing information with patients and families when a patient experiences harm. The same group is also working on a *Concerns Resolution Framework* to provide an effective and consistent process for handling complaints/concerns from patients, families and staff across and between the health regions and regulated health professions.

In addition, the HQCA has adopted a proactive approach to medication safety by developing a comprehensive multi-year agenda to work with its partners and recognized experts to systematically identify, develop, implement, evaluate and update leading practices for handling medications most often associated with adverse events.

One component of this multi-year agenda will be pursued through the *Alberta Medication Safety Collaborative*, a partnership of the Council, Alberta's health regions' pharmacy leaders and the Alberta College of Pharmacists. The collaborative is supported by recognized experts including the Institute for Safe Medication Practices Canada. This collaborative will focus on improving medication safety in acute care hospitals.

The HQCA is also exploring potential areas where we can work with our partners on other provincial-level initiatives. One way we're doing this is by supporting the Western Canadian node of the *Safer Healthcare Now!* Canadian Campaign. Supported by the Institute for Healthcare Improvement's *100K Lives Campaign*, this initiative is enlisting hospitals across Alberta and the rest of Canada to implement changes that are proven to prevent adverse events. For more information, go to: www.saferhealthcarenow.ca.

"Adverse events result from the interaction of the patient, the patient's disease, and a complicated, highly technical system of medical care provided not only by a diverse group of doctors, other care givers, and support personnel, but also by a medical-industrial system that supplies drugs and equipment. Reducing the risk of adverse events requires an examination of all these factors as well as of their relations with each other."

Leape, L.L. et al (1991)

Acknowledgements

The HQCA thanks those Albertans who participated in this survey, provided us with valuable information and shared their personal stories.

Want more details?

For a copy of the technical reports, go to **www.hqca.ca.**

We'd like to hear from you

Please take a moment to answer the following questions.

1. How did you hear about the *Alberta Patient Safety Survey*?

2. Did you find the information in the survey useful?
   Yes ☐ No ☐

3. How could we improve future publications?

4. What other topics would you like to see the HQCA focus on in the future?

5. Other comments?

Fax your comments to us at **(403) 297-8258** or mail to:

Health Quality Council of Alberta
210, 811-14 Street NW
Calgary, AB T2N 2A4
(403) 297-8162

You may also email your comments to **info@hqca.ca.**

Thank you for completing and returning this questionnaire.